Local Management Entity-Managed Care Organization (LME-MCO) Semi-Annual Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Compliance Report

Narrative Section

LME-MCO:	
State Fiscal Year:	**2015**
Report Period:	**Mid-Year Report**
	July 1, 2014 through December 31, 2014
Report Due Date:	**Tuesday, January 20, 2015**
Date Report Submitted:	

Report Submitted By:

Name:	
Title:	
Phone:	
Email:	

Please note: The LME-MCO Semi-Annual SAPTBG Compliance Report consists of two companion files – a Microsoft Excel template file and a Microsoft Word template file.

The Excel file is used to complete the parts of the report that contain data and lists, while the Word file is used to complete the sections of the report that require a narrative. Both files should be submitted together.

This is document is the Word template file for completing the narrative sections. Information may be entered directly under each heading. In addition, please attach other documents as appropriate to substantiate evidence of activities, practices, etc.

Section III: SAPTBG Primary Prevention Program Staff and Written Program Plan

Part B. Annual Strategic Prevention Plan (Written Program Plan)

In order to strengthen SAPT Block Grant planning and accountability for the 20% Set-Aside for Substance Abuse Primary Prevention Services, the LME-MCO is required to submit a written **Annual Strategic Prevention Plan,** as per APSM 30-1, T10: 14V .4200 and .6900. **This Plan is to be submitted in January with the Mid-Year Report for the upcoming state fiscal year, and updated as needed in July in the Year-End Report.**

This Plan should specify substance abuse populations that will be targeted in the coming fiscal year, including those High-Risk groups identified in Section 1C, as well as evidence-based programs to be implemented as described in Section 3C. This Plan should address Consultation and Education Services (10 NCAC 27G .6900) and include activities and services in each of the six Substance Abuse Primary Prevention Strategies as described in Licensure Rule 10 NCAC 27G, Section .4200 (APSM 30-1). Other areas required in the narrative include the following:

Section 1 – Assessment
Assessment requires a profile of population needs, resources and readiness to address problems and gaps in service delivery. This involves the:

- Collection, interpretation and analysis of relevant data to define the magnitude and locations of problems within a geographic area/community and identify at risk and underserved populations and environmental risks;
- Assessment of resources which includes cultural competence, identification of service gaps and the identification of existing prevention infrastructure; and,
- Assessment of readiness and leadership to implement and sustain policies, programs, and practices. The assessment results should establish priorities, define terms to assure consensus of understanding, and establish a purpose that unifies commitment through the following SPF steps.

Section 2 - Capacity
In this step, those within the target area who have any capability for addressing the problem(s) identified in the assessment exercise come together to pool their resources and improve these capabilities. Partnerships are developed; existing ones are strengthened; cultural competence is examined. Training and education often are used to enlarge and enhance the capacity of those expected to develop and implement an effective prevention plan. The main components of the *Capacity* part of the SPF process are:

- Identify capacities to address prioritized problems;
- Mobilize community capacity;
- Reach out to new partners;
- Nurture coalition capacity.

Section 3 - Planning
During *Planning,* a logic model is created and followed to select evidence-based programs, practices and policies, and to set goals, objectives and measurable outcomes as part of a strategic plan to address the problem(s) identified by the data examined in the *Assessment* step. The *Planning* phase may be broken down into these subtasks:

- Identify problem and intervening variables;
- Identify aim or goal;

- Clarify strategic approaches;
- Establish benchmarks/objectives;
- Identify, adapt, and select services;
- Prepare capacity and strengthen plan;
- Prepare evaluation plan;
- Finalize implementation.

Section 4 - Implementation

Implementation means doing all the things that were identified and chosen as necessary to reaching goals and objectives during planning. But more than that, *Implementation* means documenting and measuring how plans are carried out and how well they work, making course-corrections as needed and finalizing the evaluation plan. The main activities during *Implementation* are:

- Carry out planned services;
- Document implementation process;
- Analyze and evaluate implementation process;
- Modify services.

Section 5 - Evaluation

Measuring the effect of following the SPF process and the effect of what has been implemented is the purpose of *Evaluation. Evaluation* determines how programs, practices and policies might be improved to achieve better outcomes, as well as how to use the SPF steps more efficiently in the future. The future is an important concern for *Evaluation,* both in terms of lessons learned that can guide other endeavors to greater success, and for sustainability of what has been put in place. Activities within *Evaluation* will include:

- Implement evaluation plan;
- Collect data;
- Analyze data;
- Report outcomes;
- Use evaluation outcomes to make needed changes.

Section 6 - Cultural Competence

To be effective, providers of all substance abuse prevention services must be culturally competent, regardless of the goals and objectives or the identified target audience. Hence, cultural competence (along with sustainability) is necessary throughout the SPF process.

Defined as "the shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people" (*Cultural Competence for Evaluato*rs, DHHS, 1992), culture shapes how people see their world and structure community and family life. Cultural affiliation often determines values and attitudes about health issues, responses to messages and use of alcohol, tobacco, and illicit drugs. Culture is broader than race and ethnicity, and people often belong to one or more subgroups, influencing what they think and how they act. Geography, lifestyle, age, disabilities and other characteristics also affect attitudes and behavior.

Cultural Competence refers to academic and interpersonal skills, allowing people to increase their understanding and appreciation of cultural differences and similarities within and between groups. A culturally competent program demonstrates sensitivity to and understanding of cultural differences in program design, implementation, and evaluation. Such programs:

- Acknowledge cultures as a predominant force in shaping behaviors, values, and Institutions;
- Acknowledge and accept that cultural differences exist and have an impact on service delivery;
- Believe that diversity within cultures is as important as diversity between cultures;
- Respect the unique, culturally defined needs of various populations;

- Recognize that concepts such as “family” and “community” are different for various cultures and even for subgroups within cultures;
- Understand that people from different racial and ethnic groups and other cultural subgroups are usually best served by persons who are a part of or in tune with their culture;
- Recognize that taking the best of both worlds enhances the capacity of all.

Section 7 - Sustainability

Like cultural competence, *Sustainability* is an essential element of each step of the SPF.
Sustainability refers to the process through which a prevention system becomes a norm and is integrated into ongoing operations.
Sustainability is vital in ensuring that prevention values and processes are firmly established, that partnerships are strengthened and that financial and other resources are secured over the long term.
Sustainability also encourages the use of evaluation to determine which elements of a prevention program, policy or service need to be continued and supported to maintain and improve outcomes.
Because *sustainability* has a major effect on outcomes, it is an important part of the whole planning process. If the aim is to reduce underage drinking by 20%, for example, partners in the strategy need to support any programs, arrangements and adjustments that will make this happen and plan how to sustain the outcomes, not just the programs.

Please select one of the following:

☐ Annual Strategic Prevention Plan follows/is attached (Mid-year Report)
☐ Update only follows/is attached (Year-end Report)
☐ Plan is complete, no update necessary (Year-end Report)

Section IV: SAPTBG Activities for Reducing Youth Access to Tobacco Products Initiative (Synar Amendment)

Part A. LME-MCO Synar Performance Measure

Please include a narrative below of specific activities that demonstrate LME-MCO commitment and leadership to insure implementation in your local communities of the Synar Amendment provisions toward reducing youth access to tobacco products.

☐ Mid-Year information follows/is attached ☐ No updates necessary for Year-End report

Section V: Priority Admission Preference for Women Who are Pregnant and Injecting Drugs, Women Who are Pregnant and Using Substances and Other Individuals Who are Injecting Drugs

Part A. LME-MCO Policies and Practices for Assuring Priority Admission Preference

Describe your **LME-MCO program policies and practices assuring priority admission preference** for all women who are pregnant and injecting drugs, pregnant and using substances and other individuals who are injecting drugs in all LME-MCO programs and contract agencies. Describe your LME-MCO’s contract management and monitoring, training, technical assistance and quality management practices that ensure that all LME-MCO and contract agency direct services staff provide Priority Admission Preference

for all women who are pregnant and injecting drugs, pregnant and using substances and other individuals who are injecting drugs.

☐ Mid-Year information follows/is attached ☐ No updates necessary for Year-End report

Part B. Documentation of Efforts to Publicize Priority Admission

Document and/or attach evidence of satisfactory efforts of your **LME-MCO** to advertise and publicize priority admission policies **in the current fiscal year** assuring admission to all women who are pregnant and injecting drugs, pregnant and using substances and other individuals who are injecting drugs.

☐ Mid-Year information follows/is attached ☐ No updates necessary for Year-End report

Section VI: Capacity of Treatment for Individuals Who are Injecting Drugs

Part A. LME-MCO Policies and Practices for Assuring Timely Admission

Describe your **LME-MCO's policies and practices that ensure that individuals who are injecting drugs** are admitted for services within 14 days of the request for services, or if at capacity, within 120 days of the request for services, with the provision of interim services within 48 hours after the request for care if admission within 14 days is not possible.

☐ Mid-Year information follows/is attached ☐ No updates necessary for Year-End report

Section VII: Universal TB Screening, Testing, Referral and Case Management Services

Part A. LME-MCO Policies and Practices for Assuring TB Screening for Individuals with a Substance Use Disorder

Describe your **LME-MCO's universal TB screening policies for children and adults who have an identified substance use disorder for which services are being sought from a contracted provider**. Describe your LME-MCO's contract management and monitoring, training, technical assistance and quality management practices that ensure that contract agency direct services staff provide universal TB screening for all children and adults with a substance use disorder.

☐ Mid-Year information follows/is attached ☐ No updates necessary for Year-End report

B. LME-MCO Policies and Practices for Assuring Services for Individuals Identified as High Risk for TB

Describe your **LME-MCO's policies related to referral, TB testing and case management services for individuals that, through the screening process, have been identified as high-risk for TB.** Describe your LME-MCO's contract management and monitoring, training, technical assistance and quality management practices that ensure that contract agency direct services staff provide timely and appropriate referral for TB testing and case management services for individuals who have screened positive or have been identified as high-risk for TB.

☐ Mid-Year information follows/is attached ☐ No updates necessary for Year-End report

The section below is required to be completed ONLY by those LME-MCOs receiving specialized funding for HIV/Early Intervention Services (Federal SA Non-UCR HIV Account 536194, Fund 1463), which includes the following LME-MCOs: Alliance Behavioral Healthcare, Cardinal Innovations, CenterPoint Human Services, CoastalCare, East Carolina Behavioral Health, Eastpointe and Sandhills Center.

Section VIII: HIV/Early Intervention Services

A. LME-MCO Policies and Practices for HIV Testing, Pre-Test and Post-Test Counseling and Referral Services

LME-MCOs that receive SAPTBG HIV/Early Intervention Services Set-Aside Funds are required to contract for HIV/Early Intervention Services for individuals participating in treatment for a substance use disorder who are at risk for HIV disease. Describe your **LME-MCO's policies for assuring HIV pre-test counseling, testing, post-test counseling and referral services for the identified populations.** Describe your LME-MCO's contract management and monitoring, training, technical assistance and quality management practices that ensure that all contract agency designated staff provide appropriate HIV pre-test counseling, testing, post-test counseling and referral for adults and youth participating in substance abuse treatment. It should be noted that referral for confirmatory testing (if not provided by the contracted agency) and other services such as case management, health care, etc. is required for those individuals who test positive for HIV disease.

☐ Mid-Year information follows/is attached ☐ No updates necessary for Year-End report